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SECRETARY OF THE AIR FORCE

AIR FORCE TACTICS, TECHNIQUES, AND  
PROCEDURES 3-42.6  
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*Tactical Doctrine*

**USAF MEDICAL SUPPORT FOR  
SPECIAL OPERATIONS FORCES (SOF)**

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**PURPOSE:** The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. This document, AFTTP 3-42.6, provides an overview of special operations (SO) and the USAF medical tactics, techniques, and procedures (TTP) that support all special operations forces (SOF) and missions. It describes the organization, capabilities, planning, logistics, training, and operations of the Air Force Special Operations Command (AFSOC) Medical Forces—primarily the operations support medical (OSM) flights, the SOF medical elements (SOFMEs), and the special tactics forces pararescue personnel.

**APPLICATION:** This publication applies to all Air Force military and civilian personnel (including Air Force Reserve Command [AFRC] and Air National Guard [ANG] units and members). The doctrine in this document is authoritative but not directive.

**SCOPE:** Special operations missions are conducted by specially organized, trained, and equipped military forces to achieve military, political, economic, or psychological objectives by unconventional means in hostile, denied, or politically sensitive areas. OSM flights, SOFMEs, and special tactics forces pararescue personnel support SOF by providing initial response and general medical care, including limited emergency trauma care and life-sustaining capabilities. Additionally, SOFMEs provide stabilization and limited patient holding capabilities. Due to the austere or limited nature of SOF medical support, state of the art field and combat casualty and medical care is a requirement for successful medical support to SOF.

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## Chapter 1

### SOF MISSIONS AND OPERATIONAL ENVIRONMENT

#### 1.1. Missions.

**1.1.1. Principal Missions.** Special operations forces provide the National Command Authority with a broad range of capabilities and option flexibility when considering appropriate responses to crises. Specifically, United States Special Operations Command (USSOCOM) is assigned nine principal missions: unconventional warfare (UW), direct action (DA), special reconnaissance (SR), combating terrorism (CT), foreign internal defense (FID), psychological operations (PSYOP), civil affairs (CA), information operations (IO), and counterproliferation (CP) of weapons of mass destruction.

**1.1.2. Collateral Missions.** As a by-product of equipping and training for the nine principal missions, SOF acquire sophisticated technical capabilities that are readily applicable to other kinds of missions. As a result, SOF also have seven recognized collateral missions that they perform as assigned: coalition support (CS), combat search and rescue (CSAR), counterdrug (CD) activities, countermine (CM) activities, humanitarian assistance (HA), security assistance (SA), and special activities. All of these missions have become an integral part of military operations other than war (MOOTW), demanding special emphasis on casualty evacuation (CASEVAC); e.g., humanitarian and noncombatant evacuation operations (NEOs).

#### 1.2. SOF Operational Environment and Medical Support Implications.

**1.2.1.** Characteristic mission requirements of AFSOC mission profiles make it necessary to modify conventional medical planning methods for providing medical support. Special operations are high risk/high gain operations; are usually conducted on short notice; are under significant operations security (OPSEC) considerations; are generally in enemy held, denied, or sensitive territory, are **at night**, are in austere conditions; and are conducted by specially organized, trained, and equipped forces in pursuit of national objectives.

**1.2.2.** AFSOF may be tasked to support future operations that may have a greater focus on humanitarian assistance and civil affairs. The ability for AFSOC medical forces to provide general preventive and public health measures and community health care will remain a basic requirement for all deployed environments.

**1.2.3.** The challenge of AFSOC medicine is to provide the highest quality of health service support (HSS) without the benefit of all of the traditional pillars of health service support (far forward comprehensive care, deployable hospitals, dedicated evacuation system, and continental United States [CONUS] support base); without the benefit of fully developed traditional levels of care (fixed or base medical treatment facilities [MTFs]); while operating in austere and remote environments without traditional military public health and prevention measures in place; and **while operating in areas of significantly higher medical and operational threat.**

**1.2.4.** The medical threat to AFSOC forces includes battle and nonbattle injuries/trauma, mission stresses (e.g. fatigue, task saturation, loss of situational awareness, psychological stress), environmental factors (heat, cold, altitude, and night/darkness), water, food, vector-borne diseases, communicable diseases, hostile/poisonous flora and fauna, as well as enemy weapons, including ballistic, directed energy weapons (DEW), and weapons of mass destruction (WMD) (e.g., nuclear, chemical, and engineered biological agent threats).

**1.2.5.** AFSOC medical forces must be flexible and provide “state-of-the-art” field and combat casualty and medical care in a wide range of operational environments. They interface directly with sister Service medical teams and assets and must be able to function effectively within established theater medical care systems. AFSOC medical forces should expect to perform their roles at night using night vision devices and in circadian disruption. An additional and increasingly more frequent operational environment is one requiring interface with a host nation (HN) health care system (applicable when the local capability is comparable to US standards of care). Ultimately, AFSOC medical forces must be focused on sustainment of the mission performance of SOF personnel.

**1.2.6.** The AFSOC/SG is committed to providing the Commander in Chief, US Special Operations Command (USCINCSOC) the best SOF medical capability. In turn, USSOCOM and AFSOC operational commanders encourage development of state-of-the-art equipment/supplies by providing funding. USSOCOM funds the development of medical solutions to problems identified by the Biomedical Initiatives Steering Committee (BISC). The BISC collects potential projects or problems from the Theater Special Operations Commands (TSOCs) and component surgeons for prioritization. Additionally, AFSOC/CC provides limited research, development, test, and evaluation funds for local medical initiatives.

## Chapter 2

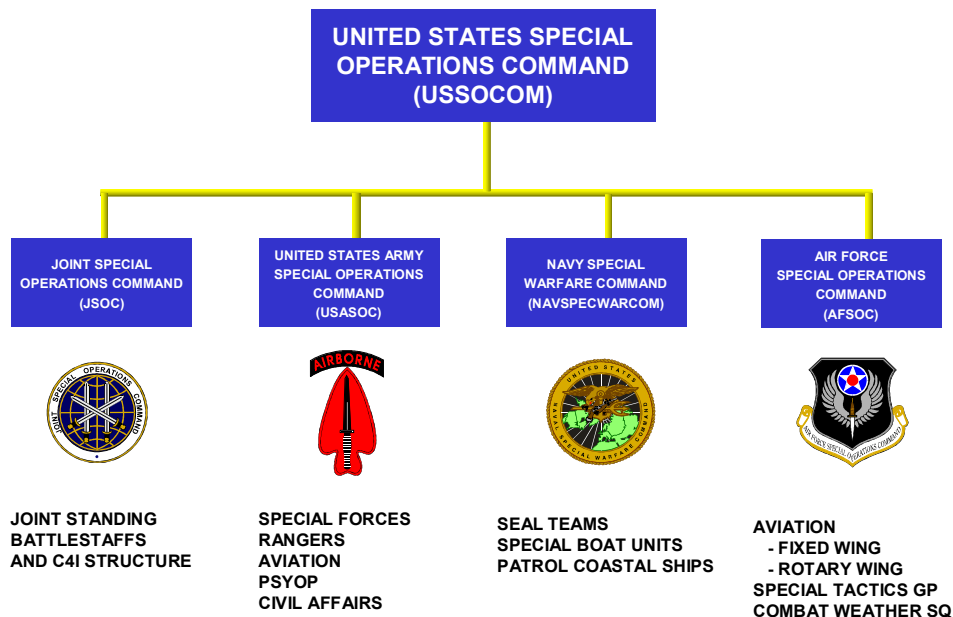
### ORGANIZATIONS, ROLES, AND RESPONSIBILITIES

#### 2.1. United States Special Operations Command (USSOCOM).

**2.1.1.** USSOCOM is a unified command at MacDill AFB, Florida. It is a support command primarily responsible for providing trained and equipped special operations personnel to theater combatant commanders. It is responsible for developing joint SOF tactics, techniques, and procedures. USSOCOM is unique among the nine unified commands in that it also has Service-like responsibilities for developing and executing a program and budget and for authorizing and funding research, development, and acquisition of SOF-peculiar items.

**2.1.2.** USSOCOM has three component commands and one sub-unified command: the US Army Special Operations Command, Fort Bragg, North Carolina; the Naval Special Warfare Command, Coronado, California; the Air Force Special Operations Command, Hurlburt Field, Florida; and the Joint Special Operations Command, Fort Bragg, North Carolina. (See Figure 2.1.)

**Figure 2.1. USSOCOM Component Commands**



#### 2.2. Air Force Special Operations Command (AFSOC).

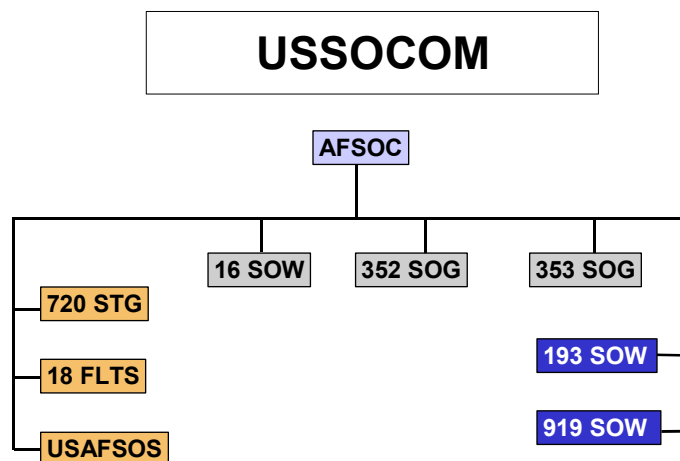
**2.2.1. Headquarters.** AFSOC is headquartered at Hurlburt Field, Florida, and functions as both an Air Force major command (MAJCOM) and as the air component of USSOCOM. As

the air component of USSOCOM, AFSOC provides Air Force special operations forces (AFSOF) to accomplish assigned special operations mission activities. As a MAJCOM, AFSOC organizes, trains, equips, administers, and maintains special operations forces for worldwide deployment and assignment to unified commands for conducting special operations activities. As the Air Force component of USSOCOM, the AFSOC commander exercises command authority consistent with operational control (OPCON) over all CONUS-based active and reserve AFSOF and PSYOP forces.

**2.2.2. Organizational Structure.** (See Figure 2.2.) AFSOC is currently organized into one special operations wing (SOW) and two special operations groups (SOGs): the 16 SOW at Hurlburt Field, Florida; the 352 SOG at RAF Mildenhall, United Kingdom; and the 353 SOG at Kadena AB, Japan. The SOGs are direct reporting units (DRUs) to AFSOC/CC. AFSOC also has three other DRUs: the 18<sup>th</sup> Flight Test Squadron, the 720<sup>th</sup> Special Tactics Group, and the US Air Force Special Operations School (USAFSOS), all located at Hurlburt Field. [The Joint Special Operations University, also at Hurlburt Field, is a DRU to USSOCOM.] Additionally, AFSOC has several air reserve components (ARC) units (e.g., 193 SOW, 919 SOW). AFSOC's 720<sup>th</sup> Special Tactics Group (STG) has six squadrons comprised of pararescue, combat weather, and combat control personnel. Special tactics forces pararescue personnel provide the joint task forces and all assigned or attached units with direct action personnel recovery, combat search and rescue, and trauma stabilization.

Figure 2.2. AFSOC Organizational Structure

## AIR FORCE SPECIAL OPERATIONS COMMAND





### **2.2.3. AFSOC Surgeon.**

**2.2.3.1.** The AFSOC Surgeon (AFSOC/SG) functions as a MAJCOM/SG and as the air component surgeon to USSOCOM. As a MAJCOM/SG, the AFSOC surgeon is responsible for establishing, coordinating, and sustaining a health care system for AFSOC personnel and for organizing, training, and equipping AFSOC medical forces for contingency medical support. As the air component surgeon to USSOCOM, the AFSOC/SG plans execution of all Air Force medical support for AFSoF and serves as the principal Air Force medical service advisor to USSOCOM.

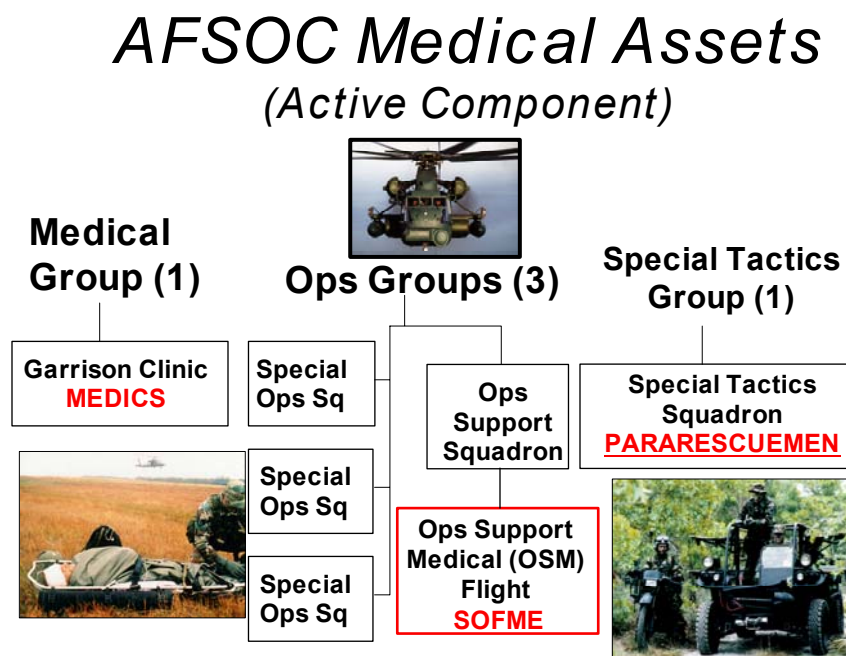
**2.2.3.2. In-garrison Health Care.** In-garrison health care supports the AFSOC mission through programs that promote force fitness and performance, preventive and acute care, and managed health care for active duty personnel and beneficiaries. Medical service efficiency is optimized through sound business practices, effective utilization management/review, and cost-effective outsourcing. For AFSOC/SG in-garrison responsibilities, refer to Air Force Special Operations Command Medical concept of operations (CONOPS).

## **2.3. AFSOC Medical Units. (See Figure 2.3.)**

**2.3.1. Medical Group.** AFSOC has one fixed-health care facility, the 16<sup>th</sup> Medical Group (MDG), at Hurlburt Field, Florida. This unit operates an outpatient clinic offering primary and other specialty health care or medical support services. Its primary mission is to support the wellness and fitness of the 16 SOW and their families by operating a community-based, aerospace, and occupational medicine-oriented outpatient clinic. The 16 MDG works directly with the 16 SOW and provides personnel augmentation and other operational mission support for 16 SOW missions. The 16 MDG and AFSOC-gained ARC medical units provide additional medical capability to meet foreign internal defense, civil affairs, and humanitarian assistance requirements.

**2.3.2. Medical Group Interface with Operations Support Medical (OSM) Flight Personnel.** OSM flight personnel are an important part of and often serve as a considerable portion of the medical capability at a particular base. Accordingly, close cooperation is required between AFSoF medical personnel and the host medical treatment facility (HMTF) to fully utilize valuable medical personnel resources. This is particularly relevant to force preparation. AFSOC medical personnel have unique missions and operational support requirements significantly beyond conventional squadron medical element (SME) doctrine.

Figure 2.3. AFSOC Medical Units



### 2.3.2. Operations Support Medical (OSM) Flights. (See Figure 2.4.)

**2.3.2.1. Chain of Command.** The OSM flights are specifically organized, trained, and equipped to support the AFSOC flying mission as well as the needs of the joint SOF medical team. The OSM flights are assigned under the operations support squadron (OSS) and report through the OSS chain of command to the SOG and SOW commanders.

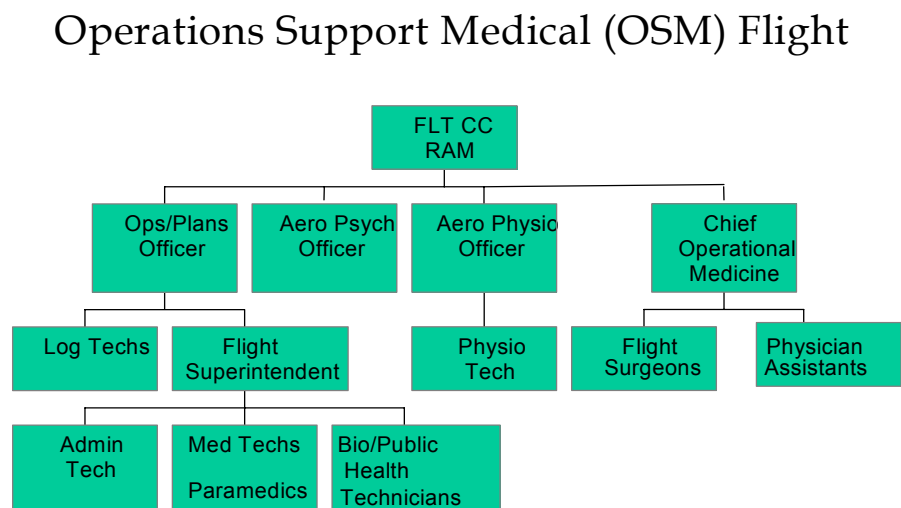
**2.3.2.2. Commander, OSM Flight.** The OSM commander ensures each medical flight maintains capabilities to provide medical support in accordance with mission capability (MISCAP) statements. Primarily, the OSM commander ensures SOF medical forces capabilities include the ability to provide support from forward areas to the SOF air-ground interface points, usually at the SOF intermediate or forward staging base (ISB/FSB). MISCAPs include capabilities for primary care, force sustainment, advanced trauma life support (ATLS), advanced cardiac life support (ACLS), preventive and aerospace medicines, medical intelligence, and casualty evacuation. Special night vision devices are used to provide these capabilities during night operations. At the ISB, casualties are transitioned to the conventional medical regulating and patient movement system. Additionally, the OSM commander ensures flight personnel can perform site surveys and gather medical intelligence information for operational deployments when required. Medical units submit medical intelligence reports to HQ AFSOC/SG for review and forwarding to Armed Forces Medical Intelligence Center (AFMIC) and other

pertinent agencies as required. For additional OSM commander responsibilities, refer to AFSOC Medical CONOPS.

**2.3.2.3. Organization.** OSM flights centrally manage the medical assets assigned to their respective Operations Group. It provides oversight of personnel management and training requirements; war reserve materiel (WRM) assets; Status of Resources and Training System (SORTS), and other reporting requirements. OSM flights focus on operational medicine; i.e., deployed medical support and CASEVAC, home-station flight medicine for the flying community and their dependents, and operational planning processes. Each OSM flight also works closely with their local base medical group in supporting Preventive Health Assessment (PHA), Commando Fitness, aviation psychology, immunizations, deployment surveillance, and health promotion/prevention programs or processes. Composition of OSM flights varies by location; however, all OSM flights have flight surgeons, medical technicians, public health and bioenvironmental engineering technicians, plans/operations officers, and organic medical logistics support. The OSM flight belonging to the 16 SOW functions as the lead OSM flight for AFSOC and utilizes physician assistants (PAs), an aerospace physiologist and technician, and a clinical psychologist.

**2.3.2.4. Roles.** The primary role of OSM flights is to establish a comprehensive deployment medicine program to support deployed AFSOC forces and to conduct casualty evacuation.

**Figure 2.4. Notional OSM Flight Organization Structure**



**2.3.3. SOF Medical Elements (SOFMEs).** SOFMEs are the deployable elements of the OSM flights and are AFSOC's core field medical teams. The SOFMEs normally consists of flight surgeons and medical technicians, but may also include specially trained physician assistants; however, medical assets will be tailored and task-organized to meet specific AFSOC mission requirements. SOFMEs have extensive medical training, supplies, and equipment to support combat casualties, and they can provide an added advanced medical capability to a deployed joint medical package.

**2.3.4. AFSOC Special Tactics Forces.** AFSOC employs specially trained and equipped forces to coordinate safe and efficient utilization of aviation assets and to perform functions that cannot be performed from fixed bases or airborne platforms. Special tactics forces consist of combat controllers, **pararescue personnel**, and combat weathermen who are organized, trained, and equipped to establish and control the air-ground interface, to rescue and recover downed aircrew members, and to provide detailed weather forecasting in the special operations objective area.

**2.3.4.1. Organization.** Special tactics forces are organized into groups, squadrons, and special tactics teams (STTs). The group consists of military and civilian support staff and deployable headquarters command and control (C2) elements. Squadrons normally consist of two or three 18-man STTs and deployable support elements. Special tactics forces are ground combat forces assigned to AFSOC, providing skills supporting special operations objectives. Additionally, **one medical logistician is assigned** to the squadron to manage medical assets used by the STT.

**2.3.4.2. Mission.** Special tactics forces perform assault zone assessment, establishment, and control; combat search and rescue or personnel recovery; trauma medical treatment; terminal attack control; and tactical weather observations and forecasting. STTs establish visual and procedural terminal area airspace control (attack, C2, and air traffic) at remote assault (drop/landing) zones at austere or expeditionary airfields.

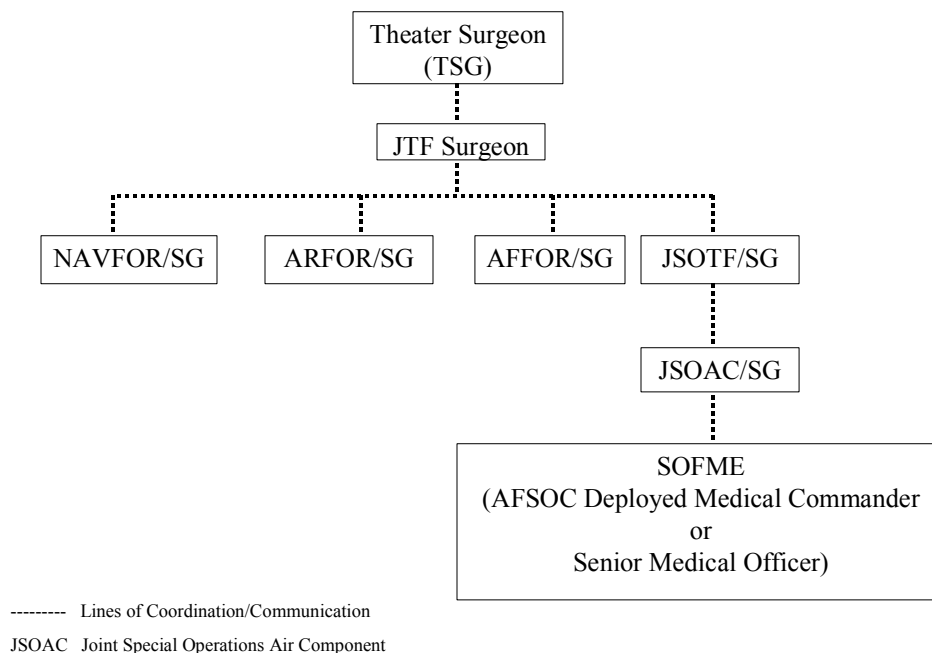
## Chapter 3

### COMMAND, CONTROL, AND COMMUNICATION

**3.1. Lines of Communication (LOC).** AFSOC medical personnel fall under the command and control of Line of the Air Force (LAF) commanders. While they report to a line commander, they are a part of, and contribute a valuable resource to, the overall medical capability of a base or operating location. AFSOC medical personnel are responsible to their parent line units for the welfare of their unit. AFSOC medical personnel may fall under the professional oversight of a conventional medical commander, i.e., when deployed along side non-SOF medical support units. In these instances, the AFSOC deployed medical commander or senior medical officer will establish the framework for cooperative efforts at the deployed location.

**3.2. Command and Control (C2).** A single airman, either the Commander, Air Force forces (COMAFFOR)/joint force air component commander (JFACC) or the joint special operations air component commander (JSOACC), will centrally control AFSOF, including AFSOF medics. When AFSOF are tasked to perform joint force special operations component commander (JFSOCC) missions, C2 should be through the JSOACC. When AFSOF are tasked to perform COMAFFOR/JFACC and JFSOCC missions, C2 will be at the discretion of the joint force commander (JFC) and should be based on the weight of mission effect. When AFSOF are tasked to perform conventional aerospace power missions, C2 should be controlled through the COMAFFOR.

**3.3. Joint Operations Command and Control (C2) Requirements. (See Figure 3.1.)** In the joint arena, AFSOC medical personnel will fall under the professional oversight of the senior medical officer on the base or operating location or, where applicable, the joint special operations task force (JSOTF) surgeon. The AFSOC deployed medical commander or senior medical officer will establish the framework for this joint cooperative effort. AFSOC medical personnel will comply with the policies of the theater surgeon (TSG) and the joint task force (JTF) surgeon when involved in a joint mission.

**Figure 3.1. Surgeon General (SG) Lines of Communication**

**3.4. AFSOC Headquarters Unit Type Code (UTC).** This LAF UTC provides the core staff for the theater AFSOF for contingency and wartime requirements. Although not a medical UTC, OSMs provide three medical personnel (flight surgeon, medical operations/plans officer, and medical technician/operations noncommissioned officer [NCO]) who are assigned to this headquarters UTC. These medical personnel can be deployed to function as the medical staff advisors to the deployed commander. In this capacity they serve as component medical planners, providing command and control of the deployed SOF medical assets, with the senior flight surgeon serving as the senior medical officer to the supported commander.

**3.5. Communication Links.** Communication links are scenario driven. Medical personnel communicate requirements through their line commanders and also through the JSOTF/SG. Medical reporting/disease surveillance requirements are accomplished in accordance with (IAW) AFI 41-106, *Medical Readiness Planning and Training*, AFI 48-101, *Aerospace Medical Operations*, USSOCOM Directive 40-4, *Medical Surveillance*, and the AFSOC Medical CONOPS.

## Chapter 4

### AFSOC MEDICAL SUPPORT FOR SOF

**4.1. Effective Management of AFSOC Medical Support.** AFSOC medical resources must be effectively and efficiently managed to provide the greatest contribution in supporting the AFSOC mission. Medical support capabilities should be encompassed in fully integrated LAF and Air Force Medical Service (AFMS) processes.

#### **4.2. AFSOC Medical Support Capabilities.**

**4.2.1. Force Preparation.** The medical groups supporting AFSOC units, with the assistance of personnel in the OSM flights, provide critical support to the AFSOC mission by preparing the force for deployed operations. SOF must be in a continual state of readiness to support minimal-notice tasking. Fitness and prompt attention to health problems are critical to assuring each member's readiness to perform in austere environments for prolonged periods.

**4.2.2. Preventive Health Assessment (PHA).** The PHA is a critical factor in force protection. The PHA screens for disease risk factors warranting intervention, assesses disease control or management, tests fitness for occupational demands, updates immunizations, and assures good oral health. Certain predeployment surveillance measures are performed with each PHA to reduce activities immediately prior to any deployment. The Commando Fitness program is the AFSOC strength and flexibility assessment used in conjunction with cycle ergometry to annually assess and encourage fitness. These measures greatly expedite AFSOC member processing for deployment and unit commanders are assured of the fitness and health of members they deploy.

**4.2.3. Disease and Injury Prevention.** Prevention is a key competency of AFSOC medics in-garrison and while deployed. Experience has shown that preventable disease and nonbattle injury can weaken or decimate force capability—a particular risk in small force packages highly dependent on the synergy gained from performance of individuals working as a team. In-garrison, prevention efforts concentrate on mitigation of health risk factors, elimination of unnecessary risks in training, and minimizing occupational injury. Efforts to minimize occupational injury include full participation in unit safety and occupational health programs. During deployed operations, AFSOC flight surgeons provide mission commanders with assessments of operational risk and suggestions for diminishing risk within mission parameters. Prevention of disease during deployments pays particular dividends in force capability through reduction of risk from disease vectors, food-borne illness, water-borne illness, toxin exposure, and endemic infectious disease.

**4.2.4. Human Performance Enhancement (HPE).** There are minimal unmanned systems within AFSOC. Therefore, performance of the AFSOC special operator is of primary importance to the AFSOC/SG. The above discussions focus on the prevention or treatment of illness and injury before, during, and after deployments. However, to provide complete medical coverage for the AFSOC special operator, AFSOC medical support must go beyond this. The AFSOC/SG is determined to fully exploit that specialized knowledge of the human

weapon system and go one step further to determine, develop, or advocate new ways to enhance the performance capabilities of all AFSOC personnel. To that end, AFSOC/SG pursues HPE on two fronts: physiological enhancements and psychological enhancements.

#### **4.2.4.1. Physiological Enhancements.**

**4.2.4.1.1.** Human limitations can be associated with physical endurance or mission duration, vision in dark environments, and altitude. There are also well known limitations to human performance secondary to exposure to enemy threats such as DEW; ballistic weapons; and nuclear, biological, and chemical (NBC) weapons. To counter the adverse effects on performance each of these represents, the AFSOC/SG must plan and advocate for countermeasures or other performance enhancement techniques or technologies. These include Laser Eye Protection (LEP) technologies, new enhanced and advanced night vision systems, chemical/biological protection systems (masks, suits, detectors, and immunobiologics/vaccines), advanced body armor, fatigue countermeasures, biological/chemical countermeasures, and high altitude/decompression sickness risk mitigation.

**4.2.4.1.2.** The 16 SOW has an Air Force-designated HPE team. This team serves as the HQ AFSOC/SG representative for aerospace physiology and aviation human factors. The team conducts research to identify specialized life support equipment to enhance special operations effectiveness; they are members of an integrated aerospace medicine team working with local flight safety and flight medicine agencies; and they provide briefings with topics tailored to unit tasking and training programs. Additionally, they support regional helicopter and high altitude parachutists with specialized human performance training.

#### **4.2.4.2. Psychological Enhancements.**

**4.2.4.2.1.** Aerospace and special operations psychology efforts employ primary, secondary, and tertiary prevention principles as a means of enhancing performance and reducing risk.

**4.2.4.2.1.1. Primary** prevention efforts are aimed at helping units modify demands, or stresses, in the day-to-day work or operational environment. Unit demands fall under at least four categories: **tasks, roles, physical conditions, and interpersonal concerns**. See Figure 4.1 for examples of unit demands in each of the four categories.



**Figure 4.1. Four Categories of Unit Demands**

**Tasks.** Examples include: risk level, mission parameters, deployments, AFSC, workload, schedules.

**Roles.** Examples include: work-home demands, role motivation, expectations.

**Physical Conditions.** Examples include: temperature, illumination, noise, exertion, airframe design.

**Interpersonal Concerns.** Examples include: leadership style, crew resource management, crew pressures, personalities, morale.

**4.2.4.2.1.2. Secondary** prevention efforts are directed at helping aircrew, special tactics forces, and squadron members respond to the necessary and inevitable demands or stresses of mission, personal, and organizational life in an optimal manner.

**4.2.4.2.1.3.** Short-term **tertiary** prevention efforts target the psychological, cognitive, or behavioral distress individuals, crews, and squadrons may encounter as the result of demand overload. To counter adverse consequences of stress and enhance performance, the AFSOC/SG supports an assortment of specific psychological performance enhancement methods. (See Figure 4.2.)

**Figure 4.2. Psychological Performance Enhancement Methods**

First, there is the technique of screening and selecting applicants for a variety of crucial special operations positions as a means of promoting best fit for AFSOC and the individual.

Second, the AFSOC Personnel Protection Program uses an aggressive combination of risk identification, prevention, and intervention methods to enhance the overall psychological health of the special operator community.

Third, specific human performance enhancement techniques such as intensity regulation, attention management, critical incident stress reduction, conflict resolution, and general stress management further advance AFSOC readiness.

Fourth, psychological consultation is available to mishap investigation boards as another means of improving flying safety. In addition, commanders are afforded easy access to human factors advice.

## Chapter 5

### EMPLOYMENT OF MEDICAL SUPPORT FOR SOF

**5.1. Premise of SOF Medical Support.** The basic premise of SOF medical support is to provide essential medical care and CASEVAC to all component SOF units deployed in support of special operations missions. In joint operations, SOFMEs provide CASEVAC capability utilizing AFSOC fixed-and rotary-wing platforms to support USSOCOM components. AFSOC medical capability includes Level 1 and limited Level 2 medical support, which is primarily aligned with AFSOC operational units. (See attachment 3 for definitions of levels of care.)

**5.2. Advanced Echelon (ADVON) Personnel.** AFSOC medics bring unique capabilities to support the deployed joint SOF commander and surgeon. SOFME personnel deploy in advance of main forces to conduct in-theater site surveys of HN facilities and to coordinate with deploying medical force planners. SOFME personnel also perform public health/bioenvironmental assessments and disease surveillance of deployed locations to minimize medical threat. ADVON personnel also secure medical site locations.

### 5.3. Employment.

**5.3.1.** SOFME personnel may be collocated with JSOTF medical agencies to combine assets for health support. Based upon identified requirements, SOFME personnel deploy a right-sized medical package to support deployed operations. Personnel and equipment UTCs are deployed incrementally with available airlift.

**5.3.2.** The AFSOC medical UTC employment concept is to deploy several UTCs in support of AFSOC missions. The SOFME and SOF Medical Kit (vest and backpack carried by each person; see attachment 2 for a description of capability) are the initial building blocks for AFSOC medical support and may be built upon as the contingency intensifies or as workload increases. The Rapid Response Deployment Kit (whole or partial) or the SOF base medical support equipment and supply package can provide additional medical supplies and equipment as requirements dictate. Additionally, AFSOC can increase its medical capability at a staging base by adding Air Force Mobile Field Surgical Teams (MFSTs), Critical Care Air Transport Teams (CCATTs), or SOFME augmentation packages. (See attachment 2 for a description of AFSOC medical UTCs.)

**5.4. Casualty and Disease Management.** The SOF mission requires medical preparation to stabilize injured or seriously ill members while moving them towards definitive care. This may occur in environments quite distant from sources of definitive care and conventional aeromedical evacuation (AE) support. AFSOC deployed capability for management of disease and injury can be characterized by four phases: **self-aid and buddy care (SABC), initial response, stabilization and treatment, and CASEVAC.** Phases two through four may overlap and occur simultaneously to varying extents, depending on the situation. If movement by air is immediately available or rendered urgent by the tactical situation, stabilization may occur during CASEVAC.

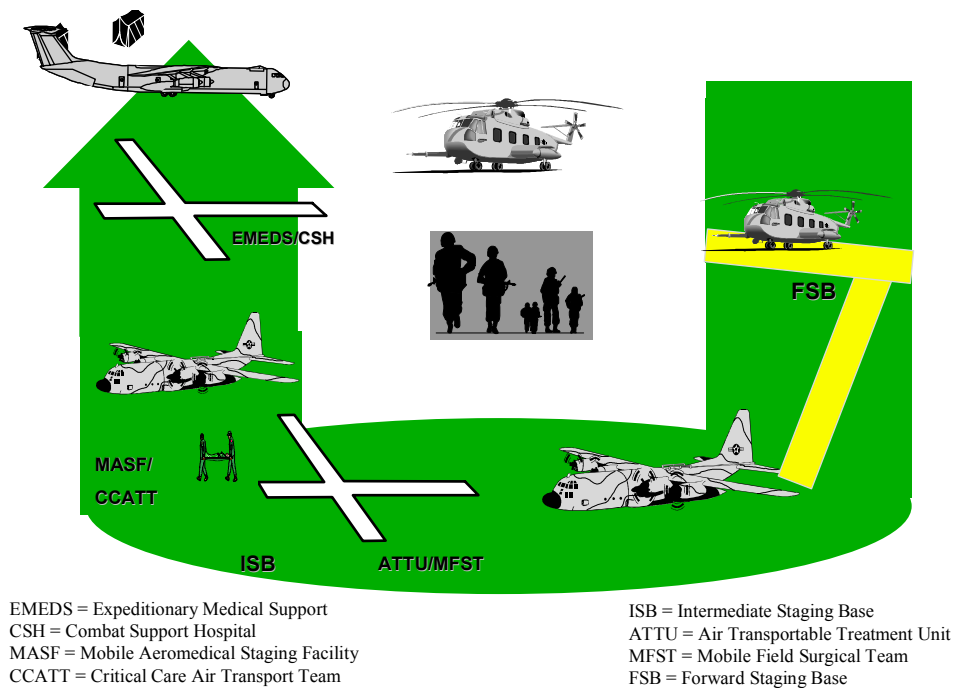
**5.4.1. Self-aid/Buddy Care (SABC).** SABC is the foundation of the medical care system. Properly trained and equipped nonmedical personnel are able to provide initial lifesaving first aid in the absence of trained medical professionals or assist medical professionals during a mass casualty situation. SABC is especially critical for AFSOC forces due to the limited number of AFSOC medics. All AFSOC personnel receive SABC training IAW Air Force directives.

**5.4.2. Initial Response/Special Tactics Forces Pararescue Support.** AFSOC special tactics forces pararescue personnel perform advanced battlefield trauma care and emergency medical treatment while in the performance of special operations missions. Special tactics forces pararescue personnel are specifically trained for combat surface operations either independently or in conjunction with other SOF forces including special forces, combat control, rangers, and sea-air-land (SEAL) teams. Although they do not hold medical Air Force specialty codes (AFSCs), the medical care rendered by AFSOC pararescue personnel falls within the professional purview and oversight of AFSOC/SG, through the 720<sup>th</sup> Special Tactics Group Surgeon. All special tactics forces pararescue personnel are trained to the emergency medical technician (EMT)-paramedic standard. Additional AFSOC pararescue capabilities include:

**5.4.2.1.** Functioning as initial responders in support of far forward personnel recovery operations.

**5.4.2.2.** Conducting casualty collection operations during direct action (DA) missions or in hostile/denied areas.

**5.4.2.3.** Providing the vital link in the transition process from personnel recovery-combat search and rescue (PR-CSAR) field missions to the CASEVAC system. CASEVAC is accomplished by the SOFMEs who have the expertise and advanced medical capabilities to receive hand-offs of casualties from the field. This transition/transloading will usually happen at the SOF ISB/FSB and can only be accomplished through concise precoordination with medical planners. Transload operations must be a dedicated aspect of every predeployment CASEVAC planning consideration. (See Figure 5.1.)

**Figure 5.1. Notional Transload/Casualty Evacuation Process**

**5.4.3. Casualty Stabilization and Disease Treatment.** Casualty stabilization is aimed at achieving a stable airway, controlling hemorrhage, treating shock, and splinting fractures. Stabilization begins with the first responders and continues as the casualty is transferred to the care of the SOFME flight surgeons and technicians and moved towards definitive care. Patients with serious disease requiring evacuation are stabilized and moved in the same fashion. Stabilization can become a prolonged phase lasting over 24-hours if host-nation care is unacceptable and strategic AE is not immediately available. Independent duty medical technicians, physician assistants, and flight surgeons in the SOFMEs manage less serious disease amenable to treatment in the forward setting.

**5.4.4. Casualty Evacuation (CASEVAC).** Operations security considerations and mission constraints often preclude the establishment of traditional AE and medical regulating systems for SOF. Responsibility for the planning and coordination of casualty evacuation and AE of SOF rests with the supported commander in chief (CINC) or joint special operations task force (JSOTF) surgeon. AFSOC has the following capabilities to support CASEVAC forward of established AE systems.

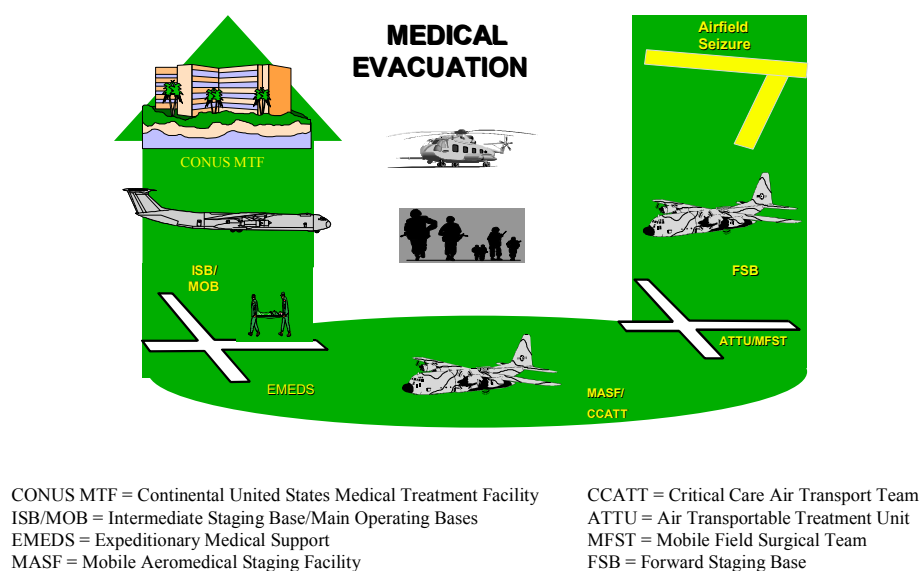
**5.4.4.1. Special Tactics Forces Pararescue Personnel.** Because of their unique skills and training, they are the appropriate resource to render trauma medical support in high threat scenarios and tactical environments. They are the only AFSOC assets with the combination of combatant, survival, and medical skills to provide trauma medical support under ground combat conditions.

#### 5.4.4.2. OSM Flight Personnel.

**5.4.4.2.1.** OSM flight personnel are trained in contingency AE procedures and are qualified to provide patient evacuation support. AFSOC aircraft conditions and mission profiles limit the extent of medical care that can be provided during flight from an objective area to the ISB/FSB where more definitive care is available. If the tactical situation permits and with the approval of the senior AFSOC line commander, OSM flight personnel can provide casualty evacuation support on AFSOC weapon systems or other opportune aircraft from secured objective locations to SOF operating bases.

**5.4.4.2.2.** OSM personnel have the capability to configure AFSOC and other aircraft of opportunity for casualty evacuation. En route, they provide medical stabilization and emergency intervention, until casualties are transitioned to the conventional medical or AE system. (See Figure 5.2.)

**Figure 5.2. Notional SOF Casualty Transition to Conventional Medical Support Units**



**5.5. Noncombatant Status.** AFSOC medical personnel are noncombatants and are not trained in combatant field craft. They must operate under the provisions of the Law of Armed Conflict and appropriate Geneva Conventions with respect to the special category considerations provided medical personnel.

## Chapter 6

### PLANNING CONSIDERATIONS

#### 6.1. Planning Casualty Care and Management Within the SOF Operational Environment.

**6.1.1. Comprehensive Medical Planning.** Comprehensive medical planning provides the backbone of operational medical support. The SOF casualty care system begins with predeployment identification of medical requirements and medical intelligence gathering. The AFSOC planner translates the requirements into a plan by identifying HN medical facility capabilities, coordinating support with the AE system, and coordinating with joint HSS agencies. Advance planning in the predeployment phase is paramount. AFSOC medical planners have access to multiple intelligence resources and gathering methods, to include Public Health resources, AFMIC, Defense Intelligence Agency (DIA), and coordination with supported theater/JSOTF medical planners. In coordination with base support agencies, AFSOC medical personnel develop preventive medicine plans and identify predeployment immunization requirements.

**6.1.2.** AFSOC medical planners must have a basic understanding of other theater medical support assets in order to ensure a seamless casualty care system. AFSOC medical forces are extremely limited in terms of extended medical operations capability and logistics base. This situation mandates the close integration, coordination, and cooperation between AFSOC medical personnel and those within established theater medical systems. While the priority of AFSOC medical forces is support of tactical AFSOC units, they comprise a valuable part of the deployed base health care system. As mission requirements allow, and with the approval/coordination of the AFSOC line commander, AFSOC medical forces may integrate with other deployed medical resources to maximize the overall base medical readiness posture.

#### 6.2. AFSOC Medical Forces Interface With the Aerospace Medical Contingency Ground Support System.

**6.2.1.** The Aerospace Medical Contingency Ground Support System, which includes the squadron medical elements (SMEs) and independent duty medical technicians (IDMTs) assigned to mobile medical units/remote sites, represents the cornerstone of medical support to Aerospace Expeditionary Force (AEF) forces deployed in any worldwide contingency.

**6.2.2.** Components of the Aerospace Medical Contingency Ground Support System are utilized to provide essential medical/dental care, deferring definitive care as dictated by theater medical CONOPS. Fixed, mature Air Force Theater Hospital (AFTH) facilities in supporting theaters receive patients from deployed medical facilities where essential medical/dental care would have been rendered. Mature AFTHs are defined as having a complete set of capabilities represented by specialty UTCs, deployable medical teams, and corresponding UTCs.

**6.2.3.** It is imperative that all AFSOC medical personnel and planners understand the particular capability inherent in each component, and specifically the HSS capability available during each phase of the Expeditionary Medical Support (EMEDS)/AFTH buildup, from EMEDS Basic to EMEDS+25 bed AFTH. This will typically be the first interface point with medical units possessing enhanced clinical capabilities and inpatient beds. (Refer to AFTTP 3-42.7, *Aerospace Medical Contingency Ground Support System*, for additional information.)

**6.2.4. SOF Casualty Interface.** Once admitted to the medical treatment facility, **SOF casualties are not regulated, evacuated, and managed similar to conventional forces.** SOF personnel normally have a separate evacuation policy to prevent personnel with critical specialties from being evacuated out of theater. At times, there is also a requirement to safeguard the patient's identity, which might compromise the unit's presence or jeopardize the mission. SOF missions are often politically sensitive.

### **6.3. Interface With the Aeromedical Evacuation (AE) System.**

**6.3.1.** Evacuation procedures employed are dependent on the special operations mission and the presence of a developed HSS system. The techniques, procedures, and equipment used to evacuate and/or extract casualties are consistent with the nature of SOF missions both principal and collateral. For additional information on evacuation procedures based on particular SOF missions, reference Joint Publication 4-02.2, *Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations*, specifically Chapter IV "Special Operations Patient Movement."

**6.3.2.** AFSOC does not possess organic conventional AE capability and must identify requirements for and obtain conventional AE support. As the air component surgeon to USSOCOM, AFSOC/SG has the responsibility for identifying and coordinating SOF aeromedical evacuation requirements. Medical support planning for SOF should include the movement of patients from forward or remote areas back to military or host nation medical treatment facilities that have the capabilities to provide the appropriate level and standard of care.

**6.3.3.** Planning should also address the interface with the conventional theater and intertheater AE system for patient movement requirements. AE for SOF may be difficult because of far forward operating locations; however, if operationally directed, AE may be tasked to go as far forward as there is a suitable airstrip. Operations at remote locations in immature theaters not served by the strategic AE system require close coordination between the supporting Air Force component command and joint medical planners. AFSOC designated AE elements may be collocated with organic medical capabilities of special operations units to complete the aeromedical evacuation process. It is important to note that patient movement planning is complicated by the nature of special operations missions that require operational security measures precluding immediate patient movement to eliminate the signature of forces in sensitive areas or compromise mission accomplishment. Further complicating planning is that some programs or missions are compartmented, and the need for operational security requires restricted access for planning purposes.

**6.3.4. Mobile Aeromedical Staging Facility (MASF)** personnel from the theater aeromedical evacuation system provide temporary holding of casualties (after initial stabilization) awaiting entry into the conventional AE system. SOF CCATTs also act as force multipliers in this scenario and possess the capability to transport stabilized casualties from the ISB to definitive care.

#### **6.4. Mission Planning.**

**6.4.1. Medical Planner.** Mission planning is paramount to the successful execution of exercises, deployments, and operations. Due to the diversity of the geographic areas of responsibility that SOF transgresses and the customers that AFSOC supports, each OSM flight has a designated medical planner to ensure the needs of the mission are met. The OSM flight planner coordinates the SOF casualty care system, logistics, and operational support with headquarters, joint, and theater planners.

**6.4.2. Provision of En Route Care in the Tactical Environment.** AFSOC aircraft conditions and mission profiles limit the extent of medical care that can be provided during flight from an objective area to the ISB/FSB where more definitive care is available. Given the constraints of the tactical environment, specific consideration should be given when planning the crew for CASEVAC missions.

**6.4.2.1.** Physicians, physician extenders, and medical technicians may be tasked to support CASEVAC missions, as determined by the deployed medical commander and the mission commander.

**6.4.2.2.** There are several scenarios where utilization of a physician or physician extender may be advantageous in supporting CASEVAC mission requirements. These include situations where the physician/physician extender can clinically improve the casualties' condition beyond medical technician capabilities. Also, medical support requirements for "precious cargo" missions may be such that the medical care expected and required exceeds medical technician capability.

**6.4.2.3.** When only one physician is available at the ISB/FSB, commanders must consider where the greatest capability is needed—on the CASEVAC aircraft or at the ISB/FSB.

#### **6.5. Modular Support Concept.**

**6.5.1. AFSOC Medical UTCs.** AFSOC medical UTCs have been developed into deployable modules utilizing the building block principle, which allows planners to select specific UTCs required to support operational requirements. This is accomplished by paring and tailoring medical assets based on specific operational needs.

**6.5.2. Resources.** UTC equipment or personnel packages are designed to be highly mobile and to support potentially austere conditions. As workload changes or is expected to



increase/decrease, these packages can be tailored, replicated, or combined with previously deployed UTCs at the needed location(s). Lean logistics concepts apply, requiring planners to identify the actual resources needed to meet specific mission requirements.

**6.5.3. Flexibility.** A major benefit derived from the modular AFSOC medical UTCs is the flexibility for incremental deployment and the overall effect of reducing transportation requirements. The SOF Medical Kit (see attachment 2 for a description of capability) allows deploying medics to hand-carry this initial response package with them on any organic AFSOC aircraft or palletize it with other mobility supplies and equipment being marshaled. Follow-on medical equipment can be transported as needed or as airlift permits or by generating a separate airlift requirement. In essence, AFSOC medical capability can still be deployed when airlift is limited.

**6.6. Theater Special Operations Commands (TSOCs).** There are joint Service medical planners assigned to TSOCs. Each of the theater unified commands has established a separate TSOC to meet the unique special operations requirements of the individual theaters. The TSOCs are subunified commands that answer directly to theater CINCs. However, each of the TSOCs work closely with USSOCOM in regards to identifying and obtaining specialized personnel and equipment to support geographic CINC taskings. The TSOCs ensure that SOF strategic capabilities are fully employed within the respective CINC's peacetime engagement plan, as well as, within the unified command contingency and operations plans. Peacetime medical engagement includes noncombatant evacuation operations (NEOs), humanitarian and civic assistance (HCA), and other mission specific training. The six TSOCs supporting geographic CINCs worldwide are Special Operations Command Central (SOCCENT), Special Operations Command Europe (SOCEUR), Special Operations Command Pacific (SOCPAC), Special Operations Command South (SOCSOUTH), Special Operations Command Korea (SOCKOR), and Special Operations Command Joint Forces Command (SOCJFCOM).

## **Chapter 7**

### **MEDICAL LOGISTICS AND WAR RESERVE MATERIEL (WRM)**

#### **7.1. Medical WRM.**

**7.1.1.** AFSOC WRM assemblages provide the SOFME with the extensive medical supplies and equipment needed to support combat casualties and disease and nonbattle injuries (DNBIs). All AFSOC WRM assemblages are packed to a standardized allowance standard (AS) to ensure interoperability between AFSOC medical personnel.

**7.1.2.** All AFSOC medical WRM packages are maintained in a “ready to deploy” configuration. Medical supply and equipment packages returned to the unit following deployment will be reconstituted in order to meet required response times in Designed Operational Capability (DOC) statements.

**7.1.3.** Documentation of medical supplies and equipment used/expended during any training or operational deployment will be maintained by AFSOC medical personnel to assist in the recovery of after-the-fact (ATF) funding as required. Details and specifics of logistical support will be provided and will be identified in applicable base support plans. Established allowance standards will be modified, as appropriate, for AFSOC medical assemblages. AFSOC medical assemblages are specifically designed for rapid load planning, deployment, employment, and reconstitution.

#### **7.2. Medical Logistics Support.**

##### **7.2.1. Medical Supplies and Equipment.**

**7.2.1.1.** Theater medical planning guidance generally requires units to deploy with a 30-day package of medical supplies. For AFSOC units, the deployment load will vary based on mission requirements and operational constraints. To determine medical logistic requirements, medical planners must consider the mission and its duration, the availability of supplies at the mission location, and the alternate medical supply sources available in the event the conventional system breaks down. AFSOC medical forces currently possess limited logistical support capabilities. AFSOC medical units have medical stock record accounts at home station, but may depend on local base/host medical treatment facilities for various types of medical logistics support, linen control (as applicable), and biomedical equipment repair support.

**7.2.1.2.** In many SOF operations the nature of the operation (covert, short-term, etc.) does not allow or require a resupply mechanism to be established. In these cases, adequate medical supplies and equipment are deployed with AFSOF to ensure capability exists to support operational requirements. When resupply is required, SOF medical planners establish resupply through a variety of mechanisms to include: support from a host medical treatment facility; in-country embassy or Military Assistance Group (MILGRP); home station or main operating base. When deployed in support of a major regional conflict,

AFSOF medical logistics support is provided by the conventional HSS system (reference AFTTP 3-42.8, *Medical Logistics and Blood Support Operations*). Because of the austere nature of SOF medical capability, expeditionary combat support is required for messing; billeting; petroleum, oils, and lubricants (POL); linen control; biomedical equipment repair/calibration; and other support requirements. Preplanning is essential to mission success.

#### **7.2.2. Management of Blood and Associated Items (Class VIII Materiel).**

**7.2.2.1.** This category consists of blood products, volume expanders, and resuscitative fluids. This is separately addressed because of special transport, storage, and use requirements. AFSOC will rely primarily on volume expanders and will seldom use whole blood. However, whole blood may be needed in specific cases. If required, OSM flights establish a written agreement with the local military treatment facility commander specifying the number of units required and a predetermined time frame for pick-up. Additionally, measures for transportation and cold storage of this perishable supply item must be coordinated or arranged. Finally, OSM flights arrange for the resupply of less perishable but high turnover Class VIIIB items (such as volume expanders) through established/theater medical logistics channels (reference AFTTP 3-42.8, *Medical Logistics and Blood Support Operations*).

**7.2.2.2.** AFSOC medical technicians will be trained and qualified in administering volume expanders, blood products, and resuscitative fluids. In an emergency situation medical technicians may administer whole blood with physician oversight.

## Chapter 8

### TRAINING

**8.1. Joint Medical Training Standards.** Successful joint interoperability is achieved through joint medical training standards. Special Operations Combat Medic (SOCM) is the current standard (as outlined in USSOCOM Directive 40-2, *Medical Service*) in which all component medics and pararescue personnel use as a baseline.

**8.2. AFSOC Medical Training Program.** The AFSOC medical training program is designed to meet the unique challenges of special operations duty. There is considerable resource investment required to fully train AFSOC medical personnel and then maintain a “mission ready” status. This involves substantial time and a commitment to operational excellence. AFSOC/SG will remain fully engaged in efforts to ensure ongoing review and enhancement of medical training requirements and programs for AFSOC personnel.

### **8.3. Comprehensive Training.**

**8.3.1.** AFSOC medical forces represent a sophisticated and highly capable medical response capability. Comprehensive medical and line training programs are required to develop and sustain perishable medical and operational skills. For AFSOC operational medical units, this involves preparing to provide primary care, emergency medical support, force health protection, limited CASEVAC, and short-term casualty staging prior to evacuation for further definitive care. All AFSOC operational medical personnel and special tactics forces pararescue personnel will meet additional training requirements associated with mobility status, and in accordance with AFSOC Medical CONOPS.

**8.3.2.** AFSOC/SG schedules and tracks EMT-Paramedic training for operational medics and special tactics forces pararescue personnel. A quarterly report is forwarded to USSOCOM for consolidation into an all SOF medical forces report. Training and tracking of additional requirements will be managed at the OSM flight. Additionally, OSM flight commanders should ensure training of their personnel to operate in the airborne environment on AFSOC and/or other opportune aircraft. This will include medical and aircraft emergency procedures, egress training, use of aircraft emergency equipment, and in-flight medical care, including advanced life support (ALS) skills performed primarily during low level, low light/blackout conditions. Units will be proficient in transload and engines running on/off-loads (EROs) procedures.

LANCE L. SMITH, Major General, USAF  
Commander, Air Force Doctrine Center

## Attachment 1

## GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

*References*

JP 3-05, *Doctrine for Joint Special Operations*  
 JP 4-02, *Doctrine for Health Service Support in Joint Operations*  
 USSOCOM Pub 1, *Special Operations in Peace and War*  
 USSOCOM Directive 40-4, *Medical Surveillance*  
 AFDD 2-4.2, *Health Services*  
 AFMAN 10-401, *Operation Plan and Concept Plan Development and Implementation*  
 AFM 23-110 Vol 5, *Air Force Medical Materiel Management System*  
 AFI 41-106, *Medical Readiness Planning and Training*  
 AFI 41-302, *Aeromedical Evacuation Operations and Management*  
 AFI 41-304, *Aeromedical Evacuation and Education*  
 AFI 48-101, *Aerospace Medical Operations*

*Abbreviations and Acronyms*

ACLS..... advanced cardiac life support  
 ADVON..... advanced echelon  
 AE..... aeromedical  
 AEF..... Aerospace Expeditionary Force  
 AFFOR..... Air Force forces  
 AFMIC..... Armed Forces Medical Intelligence Center  
 AFMS..... Air Force Medical Service  
 AFRC..... Air Force Reserve Command  
 AFSC..... Air Force specialty code  
 AFSOC..... Air Force Special Operations Command  
 AFSOF..... Air Force special operations forces  
 AFTH..... Air Force Theater Hospital  
 AFTTP..... Air Force Tactics, Techniques, and Procedures  
 ALS..... advanced life support  
 ANG..... Air National Guard  
 ARC..... air reserve components  
 ARFOR..... Army forces  
 AS..... allowance standard  
 ATF..... after the fact  
 ATLS..... advanced trauma life support  
 ATTU..... Air Transportable Treatment Unit  
 BISC..... Biomedical Initiatives Steering Committee  
 BW..... biological warfare  
 C2..... command and control  
 CA..... civil affairs  
 CASEVAC..... casualty evacuation

CCATT.....	Critical Care Air Transport Team
CD.....	counterdrug
CINC.....	commander in chief
CM.....	countermine
COMAFFOR.....	Commander, Air Force Forces
CONOPS.....	concept of operations
CONUS.....	continental United States
CP.....	counterproliferation
CS.....	coalition support
CSAR.....	combat search and rescue
CSH.....	combat support hospital
CT.....	combating terrorism
CW.....	chemical warfare
DA.....	direct action
DEW.....	directed-energy warfare
DIA.....	Defense Intelligence Agency
DNBI.....	disease and nonbattle injury
DOC.....	Designed Operational Capability
DRU.....	direct reporting unit
DVA.....	Department of Veteran Affairs
EMEDS.....	Expeditionary Medical Support
EMT.....	emergency medical technician
ERO.....	engines running on/off-loads
FARP.....	forward area refueling point
FID.....	foreign internal defense
FSB.....	forward staging base
HA.....	humanitarian assistance
HCA.....	humanitarian and civic assistance
HMMWV.....	high mobility multipurpose wheeled vehicle
HMTF.....	host medical treatment facility
HN.....	host nation
HPE.....	Human Performance Enhancement
HSS.....	health service support
IAW.....	in accordance with
IDMT.....	independent duty medical technician
IO.....	information operations
ISB.....	intermediate staging base
JFACC.....	joint force air component commander
JFC.....	joint force commander
JFSOCC.....	joint force special operations component commander
JSOAC.....	joint special operations air component
JSOACC.....	joint special operations air component commander
JSOC.....	Joint Special Operations Command
JSOTF.....	joint special operations task force
LAF.....	Line of the Air Force
LEP.....	Laser Eye Protection

LOC.....	lines of communication
MAJCOM.....	major command
MASF.....	Mobile Aeromedical Staging Facility
MDG.....	medical group
MFST.....	Mobile Field Surgical Team
MILGRP.....	Military Assistance Group
MISCAP.....	mission capability
MOB.....	main operating base
MOOTW.....	military operations other than war
MTF.....	medical treatment facility
NAVFOR.....	Navy forces
NAVAIDS.....	navigation aids
NAVSPECWARCOM.....	Naval Special Warfare Command
NBC.....	nuclear, biological, and chemical
NCO.....	noncommissioned officer
NEO.....	noncombatant evacuation operation
OCONUS.....	outside the continental United States
OPCON.....	operational control
OPSEC.....	operations security
OSM.....	operations support medical
OSS.....	operations support squadron
PA.....	physician assistant
PHA.....	Preventive Health Assessment
POL.....	petroleum, oils, and lubricants
PR.....	personnel recovery
PSYOP.....	psychological operations
RAM.....	resident in aerospace medicine
RRDK.....	Rapid Response Deployment Kit
RTD.....	return to duty
SA.....	security assistance
SABC.....	self-aid and buddy care
SEAL.....	sea-air-land
SG.....	surgeon general
SME.....	squadron medical element
SMO.....	Senior Medical Officer
SO.....	special operations
SOCENT.....	Special Operations Command Central
SOCEUR.....	Special Operations Command Europe
SOCJFCOM.....	Special Operations Command Joint Forces Command
SOCKOR.....	Special Operations Command Korea
SOCM.....	Special Operations Combat Medic
SOC PAC.....	Special Operations Command Pacific
SOC SOUTH.....	Special Operations Command South
SOF.....	special operations forces
SOFME.....	special operations forces medical element
SOG.....	special operations group

SORTS.....	Status of Resources and Training System
SOW.....	special operations wing
SR.....	special reconnaissance
STG.....	special tactics group
STT.....	special tactics team
TSG.....	theater surgeon
TSOC.....	Theater Special Operations Command
TTP.....	tactics, techniques, and procedures
USAF.....	United States Air Force
USAFSOS.....	USAF Special Operations School
USASOC.....	US Army Special Operations Command
USCINCSOC.....	Commander in Chief, US Special Operations Command
USSOCOM.....	US Special Operations Command
UTC.....	unit type code
UW.....	unconventional warfare
WMD.....	weapons of mass destruction
WRM.....	war reserve materiel

### ***Terms***

**aeromedical evacuation (AE)** – The movement of patients under medical supervision to and between medical treatment facilities by air transportation. (JP 1-02)

**aeromedical evacuation system** – A system which provides: (a) control of patient movement by air transport; (b) specialized medical aircrew, medical crew augmentees, and specialty medical attendants and equipment for inflight medical care; (c) facilities on or in the vicinity of air strips and air bases for the limited medical care of intransit patients entering, en route via, or leaving the system; and (d) communication with originating, destination, and en route medical facilities concerning patient transportation. See also **aeromedical evacuation**. (JP 1-02)

**casualty evacuation (CASEVAC)** – The movement of casualties. It includes movement both to and between medical treatment facilities. Any vehicle may be used to evacuate casualties.

**pararescue team** – Specially trained personnel qualified to penetrate to the site of an incident by land or parachute, render medical aid, accomplish survival methods, and rescue survivors. (JP 1-02)

**special operations** – Operations conducted by specially organized, trained, and equipped military and paramilitary forces to achieve military, political, economic, or informational objectives by unconventional military means in hostile, denied, or politically sensitive areas. These operations are conducted across the full range of military operations, independently or in coordination with operations of conventional, non-special operations forces. Political-military considerations frequently shape special operations, requiring clandestine, covert, or low visibility techniques and oversight at the national level. Special operations differ from conventional operations in degree of physical and political risk, operational techniques, mode of employment,



independence from friendly support, and dependence on detailed operational intelligence and indigenous assets. Also called **SO**. (JP 1-02)

**special operations forces** – Those active and reserve component forces of the military Services designated by the Secretary of Defense and specifically organized, trained, and equipped to conduct and support special operations. Also called **SOF**. (JP 1-02)

**special tactics team** – USAF special operations forces with combat controllers assigned. The combat controllers are certified air traffic controllers with additional qualifications as Special Operations Terminal Attack Controllers for fire support operations. Also called **STT**. (JP 1-02)

**transload** – Transfer of casualties from one airframe to another, in the immediate proximity. For example, using an MH-53M to MC-130P, to facilitate evacuation from forward areas. Performed across spectrum of permissive environments, primarily during nighttime operations with engines running.

## Attachment 2

### AFSOC MEDICAL UNIT TYPE CODES (UTCs)

#### A2.1. SOF Medical Personnel UTCs.

**A2.1.1. Special Operations Forces Medical Element (SOFME).** This is the basic medical personnel unit, which forms the foundation and first module in the building block approach to the AFSOC medical support system. It consists of one flight surgeon and two independent duty medical technicians. The technicians are extensively trained in operational medicine and are certified EMT-Paramedics. SOFME may also include medical support by AFSOC physician assistants (PAs) who also receive extensive training in operational medicine. PAs are capable of providing medical support in any type of environment and providing support for forward CASEVAC. The SOFME deploys with a SOF medical kit consisting of trauma vests and backpacks for initial life saving measures and treatment. The vests and backpacks are easily accessible for short notice taskings and “first response” requirements. The kit provides medical supplies and equipment for immediate trauma life support on the ground or during CASEVAC missions. The task of the SOFME is to take care of the warfighters by providing quality medical care in various operational environments. Prevention and treatment of disease and illness is recognized as a force multiplier and a mission requirement. SOFMEs provide primary care, force sustainment, advanced trauma life support (ATLS), advanced cardiac life support (ACLS), preventive and aerospace medicine, and CASEVAC from far forward to the SOF air-ground interface point (e.g. staging base). They are capable of configuring AFSOC and opportune aircraft to carry casualties, providing en route stabilization and intervention until transition to EMEDS/AFTH components or the AE system.

**A2.1.2. SOFME Augmentation.** This personnel and equipment package is designed to augment bare base operations that are serviced by SOFMEs. The package enhances capability to perform food safety, field hygiene/sanitation, vector surveillance, communicable disease control tasks, medical logistics, and operational planning. Additionally, it provides NBC detection, limited patient decontamination capability, and long-term industrial sustainability (industrial hygiene and environmental protection surveillance). This 4-person package consists of a medical planner, physician assistant, bioenvironmental engineering technician, and public health technician. Suitable substitutions also make this a flexible and diverse UTC.

#### A2.2. SOF Medical Equipment UTCs.

**A2.2.1. Rapid Response Deployment Kit (RRDK).** This AFSOC-unique medical equipment and supply kit is used in conjunction with or in addition to the SOFME personnel package. This kit is modularized into four separate components with associated project codes for maximum flexibility. The components are the Advanced Resuscitation Module, Trauma Module (X2), Environmental Module, and Medical Module. The kit provides for trauma, limited sick call, preventive medicine, and emergency medical treatment resources to a deployed AFSOC unit for durations up to 30 days without resupply based on medical

intelligence data. The kit does not provide for self-sufficiency and requires a building(s) of opportunity in which to operate. Generally, the RRDK provides man-portable medical supplies and equipment needed to support short-term tactical deployments for a population at risk of 200-400 personnel for 30 days. The Advanced Resuscitation Module is comprised of supplies and equipment to support in-flight cardiac life support for combat casualties. The Trauma Module has equipment for performing advanced life support procedures during mass casualty situations or in support of a casualty collection point. The Environmental Module includes equipment and supplies utilized for conducting public health threat assessments at a deployed location. The Medical Module includes pharmaceuticals and other supplies required to support “sick call”/primary care.

**A2.2.2. Base Medical Support (Air Transportable Treatment Unit [ATTU]).** This self-sufficient equipment and supply package provides primary care and emergency medical support to deployed forces for up to 30 days without resupply. It consists of three modules: Air Transportable Treatment Unit (ATTU), Laboratory Module, and biological warfare (BW)/chemical warfare (CW) Treatment Module. The primary component of this UTC is the ATTU, which is a mobile medical treatment facility transported complete with generators, an environmental control unit, and tents on a trailer. The Laboratory Module comprises equipment and supplies to perform limited manual laboratory testing. The BW/CW Treatment Module includes supplies to minimally treat previously decontaminated casualties exposed to chemical or biological agents. This is not a decontamination module. Normally collocated with a deployed AFSOC flying unit, the ATTU provides an environmentally controlled shelter and can also provide for staging of 10 litter patients for aeromedical evacuation. It is deployed with RRDKs and is self sufficient for short periods, but requires base operating support when deployed for an extended duration.

**A2.3. Augmentation of SOF Medical UTCs.** When increased trauma response and critical care capability is required at an ISB or FSB, AFSOC medical assets are augmented by a SOF Mobile Field Surgical Team and a SOF Critical Care Air Transport Team from other Air Force MAJCOMs.

**A2.3.1. SOF Mobile Field Surgical Team (MFST).** This personnel, equipment, and supply package provides resuscitative surgery and advance trauma life support for 20 casualties for up to 48 hours of continuous operation. The 5-member team and accompanying supply and equipment package (approximately 600 lbs) can be airlifted in any aircraft down to the size of a C-21 fixed-wing aircraft, or a UH-60 BLACKHAWK rotary-wing aircraft. Ground transportation can be accomplished in a single high mobility multipurpose wheeled vehicle (HMMWV), field ambulance or larger size vehicle. The equipment package is organized such that it can be palletized as personal or professional gear. The majority of supplies and equipment are maintained in five man-portable field packs. The ability to attain initial operating capability within 15 minutes is dependent upon the back packs being available to the team members immediately upon arrival at the site. The team requires shelter and potable water to be operational. Once operational, the MFST can be self-sufficient for 48 hours and then requires normal base operating support. The 5-person team includes: an emergency service physician, an orthopedic surgeon, a general surgeon, an anesthesiologist, and a surgical medical technician.

**A2.3.2. SOF Critical Care Air Transport Team (CCATT).** This personnel, equipment, and supply package provides critical care medical management to AFSOC casualties transiting the SOF casualty evacuation system. The team provides continued trauma and post-operative medical support aboard SOF aircraft and other opportune evacuation platforms. The 3-person team includes: a critical care physician, a critical care nurse, and a cardiopulmonary laboratory technician.

#### **A2.4. Medical Support to Special Operations Forces Line UTC.**

**A2.4.1. AFSOC Headquarters UTC.** OSM flights provide medical personnel assigned to the AFSOC headquarters UTC. Three personnel (flight surgeon, medical operations/plans officer, medical technician/operations noncommissioned officer [NCO]) can be deployed to be the medical staff advisors to the deployed commander. In this capacity they serve as the component medical planners, provide command and control of SOFMEs, and serve as the senior medical officer (SMO) to the supported commander.

**A2.4.2. Special Tactics Operations Flight.** This 18 person UTC provides positive control of the terminal objective area aviation environment during operations. It provides and supports: combat personnel/equipment search and recovery; casualty care, treatment, staging, and evacuation; technical extrication; and high/low angle rescue. It also provides strategic reconnaissance/surveillance; terminal attack control; forward area refueling point (FARP) control; siting/operation of navigational aids (NAVAIDS)/beacons; communications; and assault zone selection, assessment, survey, and establishment. It can support 24-hour operations for one airfield/landing zone or three combat search and rescue (CSAR) teams for up to 14 days, or be divided into smaller elements as mission requirements dictate.

### Attachment 3

#### LEVELS OF CARE

**A3.1. The Health Service Support System.** The Health Service Support (HSS) system consists of five levels of care. Patients are transported through various modes between these levels. These levels, and the increasing degree of medical capabilities, are defined below. Patient movement forward of Level 3 is a Service responsibility, but if operationally directed, AE may be tasked to go as far forward as there is a suitable airstrip.

#### **A3.2. Levels of Care.**

**A3.2.1. Level 1 (L1) -- First Responder.** Level 1 care consists of care rendered at the unit level. It includes self-aid, buddy aid, combat lifesaver skills, examination, and emergency lifesaving measures such as the maintenance of the airway, control of bleeding, prevention and control of shock, splinting or immobilizing fractures, and prevention of further injury. Treatment may include restoration of the airway by invasive procedure; use of intravenous (IV) fluids and antibiotics; and application of splints and bandages. These elements of medical management prepare patients for return to duty (RTD) or for transportation to a higher level of care.

**A3.2.2. Level 2 (L2) -- Casualty Collection and Forward Resuscitative Surgery.** Level 2 care, at a minimum, includes resuscitation and stabilization and may include advance trauma management, emergency medical procedures, forward resuscitative surgery capability, basic laboratory, limited x-ray, pharmacy, and temporary holding facilities. Patients are treated and returned to duty, or are stabilized for evacuation to an MTF capable of providing a higher level of care.

**A3.2.3. Level 3 (L3) -- Theater Hospital—EMEDS+10/25 Bed AFTH.** Level 3 care includes clinical capabilities normally found in an MTF that is located in a lower-level enemy threat environment. The MTF is staffed and equipped to provide resuscitation, initial wound surgery, and post-operative treatment. This level of care may be the first step toward restoration of functional health, as compared to procedures that stabilize a condition to prolong life. It does not normally have the crisis aspects of initial resuscitative care and can proceed with greater preparation and deliberation.

**A3.2.4. Level 4 (L4) -- Mature Theater Hospital—EMEDS+50 Bed AFTH and Up.** Level 4 care provides the surgical capabilities found at Level 3, and also provides rehabilitative and recovery therapy for those who can RTD within the theater evacuation policy. This level of care may only be available in mature theaters. The mature theater hospital may be an outside the continental United States (OCONUS) fixed medical treatment facility.

**A3.2.5. Level 5 (L5) -- Definitive Care—Large Fixed Facility CONUS or CINC Approved Safe Haven.** Level 5 care is definitive, convalescent, restorative, and rehabilitative and is normally provided by military, Department of Veteran Affairs (DVA),

CONUS civilian hospitals, and CINC-approved safe havens. This level may include a period of minimal care and increasing physical activity necessary to restore patients to functional health and allow them to RTD or useful and productive life.